Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Crohn's Disease	ICD 10 Code: K50.90	☐ Left sided Colitis	ICD 10 Code: K51.5
☐ Ulcerative Chronic Pancolitis	ICD 10 Code: K51.0	☐ Other ulcerative colitis or unspecified without complications	ICD 10 Code: K51.8
☐ Ulerative (Chronic) Proctitis	ICD 10 Code: K51.2		
☐ Ulcerative (Chronic) rectosigmoiditis	ICD 10 Code: K51.3	☐ Ulcerative Colitis	ICD 10 Code: K51.9
☐ Inflammatory polyps of colon	ICD 10 Code: K51.4	☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes supporting primary diagnosis
☐ Confirmed negative TB testing
☐ LFT and Bilirubin prior to each dose

List Tried & Failed Therapies, including duration of treatment:
1) 2)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Medication	Dosing/Diluent	Route	Rate of Infusion	Dates of administration
☐ J3590 Skyrizi for Crohn's induction	600mg mixed in D5W as per pharmacy	IVPB	1 hour	Week 0: _____ Week 4: _____ Week 8: _____
☐ J3590 Skyrizi for Ulcerative Colitis induction	1200mg	IVPB	2 hour	Week 0: _____ Week 4: _____ Week 8: _____

☐ Maintenance injections to be initiated and managed by ordering physician. Please ensure injections are approved prior to sending referral for induction doses.

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS / INFORMATION

Hold treatment if the patient has any infections prior to infusion

PRESCRIBER INFORMATION

Prescriber name :

Office Phone: | Office Fax: | Office Email:

Prescriber Signature: | Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204 Mattoon, IL 61938
Ph. 217-258-4150 Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201 Effingham, IL 62401
Ph. 217-342-7500 Fax 217-342-7499

INFUSION ORDERS - SKYRIZI® (risankizumab-rzaa)

Clinics Scan to: Physician Orders